

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be assured within 24 hours after death, prior to being retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please number carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed.

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 5 3 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Doris</i>			FIRST <i>Doris</i>	MIDDLE <i>BEACHY</i>	LAST	2a. DATE OF DEATH <i>3-20-86</i>	MONTH DAY YEAR	2b. HOUR <i>6:20 A.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>August 2, 1900</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Garrett</i>		
10. CITY OR TOWN OF DEATH <i>Oakland</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dennett Road Manor Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>School Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>High School</i>		
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Garrett</i>	13c. CITY OR TOWN <i>Oakland</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Rt. 2 Box 88</i>		21550	
14. FATHER'S NAME FIRST <i>Taney</i>		MIDDLE -----	LAST <i>Harrison</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Flora</i>		MIDDLE <i>May</i>	LAST <i>White</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-38-5997</i>		17. INFORMANT <i>Fred E. Beachy</i>		ADDRESS <i>See #13 Above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic vascular disease</i> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>In Sulfin Dependent Diabetes mellitus</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>1982</i> , 19, to <i>3-20</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3-19-86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) (did not) view the body after death.								
22b. SIGNATURE <i>George R. Stoltzfus MD</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3-21-86</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George R. Stoltzfus MD</i>		22f. ADDRESS <i>Maple St. Friendsville, Maryland 21531</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/22/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Garrett Co. Mem. Gdns.</i>		23d. LOCATION CITY OR TOWN <i>Oakland</i>		
24. FUNERAL DIRECTOR NAME <i>Bradley A. Stewart Oakland, Maryland 21550</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>MAR 31 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Jude A. Stewart</i>		



072192

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event,

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 0 8 5 3 5	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1a. DECEASED NAME (TYPE OR PRINT) Hilda May Beavers			March 7, 1986							1:15 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN Md (INTR))		7b. CITIZEN OF WHAT COUNTRY? USA		Aug. 29, 1907			78 YRS		MONTHS DAYS		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.									
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Cuppett-Weeks Nursing Home				12a. USUAL OCCUPATION Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md Allegany Lonaconing			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS ZIP CODE 3 Front St. 21539			Formerly of	
14. FATHER'S NAME Charles			MIDDLE Shook		15. MOTHER'S MAIDEN NAME Alice			MIDDLE unk.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? None (WAR OR DATES)			16b. SOCIAL SECURITY NO. 212-74-8863			17. INFORMANT Eloise Nicol, Gills Hill, Lonaconing, Md			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) metastatic cancer of brain (c) cancer of colon										4 months 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic depression											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-15-1985 to 3-7-1986, that (I) (we) last saw the deceased alive on 3-5-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3-7-86	
22b. SIGNATURE Walter Naumann MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Naumann MD		22e. ADDRESS Accident MD 21520									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-10-86		23c. NAME OF CEMETERY OR CREMATORIAL Bloomington Cemetery			23d. LOCATION Bloomington AT Allegton Md				
24. FUNERAL HOME NAME Etchhorn Funeral Home, Lonaconing, Md.		25a. DATE REC'D. BY REGISTRAR MAR 11 1986			25b. REGISTRAR'S SIGNATURE						
(VRA 15.4)											

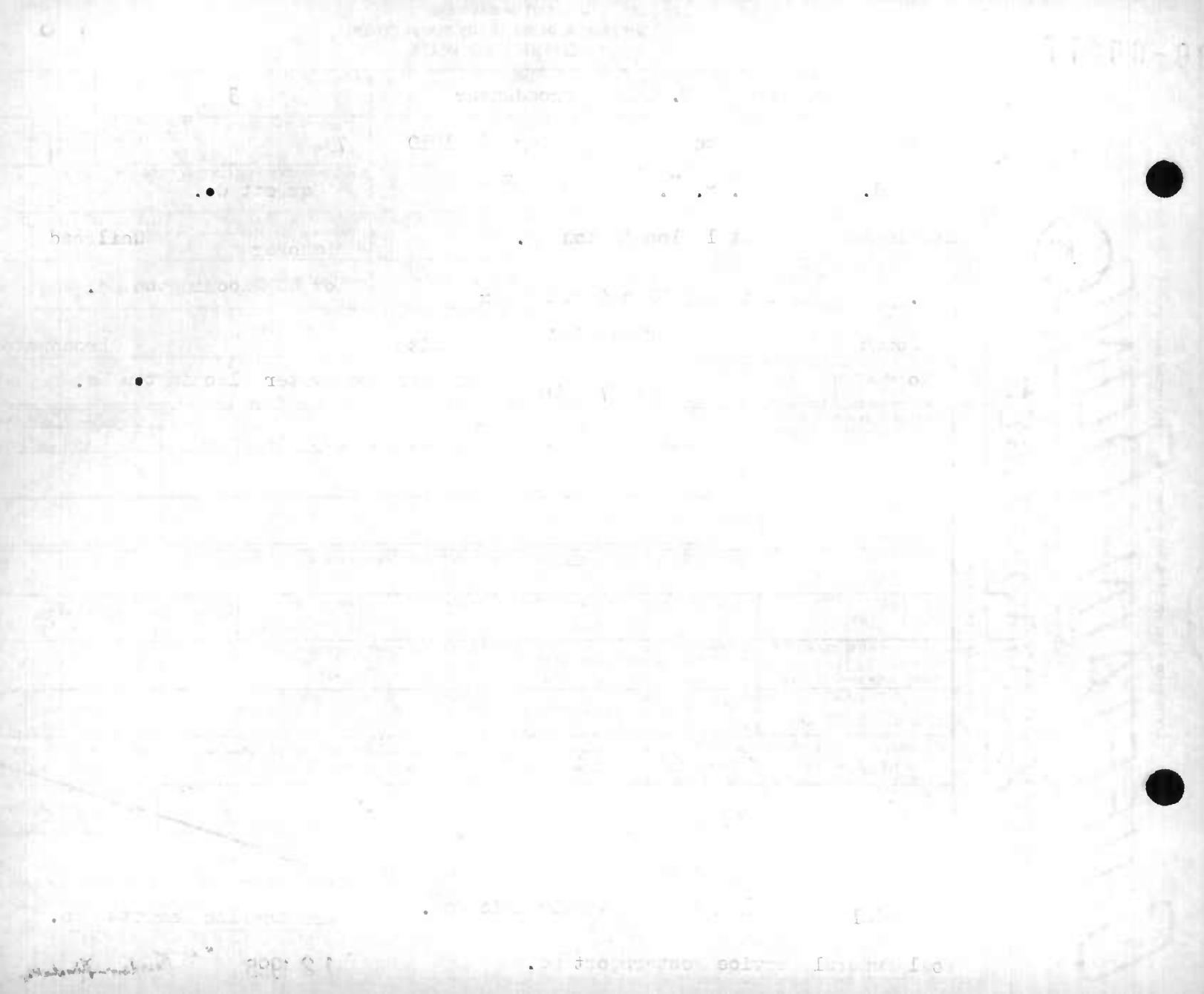
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 00-00077		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH 3 6 86				2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST William	MIDDLE T.	LAST Broadwater								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MAY 8 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co.		MD.				
10. CITY OR TOWN OF DEATH Bloomington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Mt. St. Bloomington Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Bloomington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 40 Bloomington Md.				
14. FATHER'S NAME FIRST Jones		MIDDLE Broadwater		15. MOTHER'S MAIDEN NAME FIRST Edith		LAST Broadwater						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 07 2720		17. INFORMANT Mrs Lena Broadwater Bloomington Md.		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>19 Mar 86</u> to <u>31 Dec 1986</u> , that (I) (we) last saw the deceased alive on <u>14 Dec 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Lena Broadwater</i> DEGREE												
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <u>3/10/86</u>									
22e. ADDRESS <i>Pleasant St. 26750</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>3/9/86</u>		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cem.		23d. LOCATION CITY OR TOWN		STATE				
24. FUNERAL DIRECTOR NAME Boal Funeral Service Westernport Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Mar 12 1986</u>						



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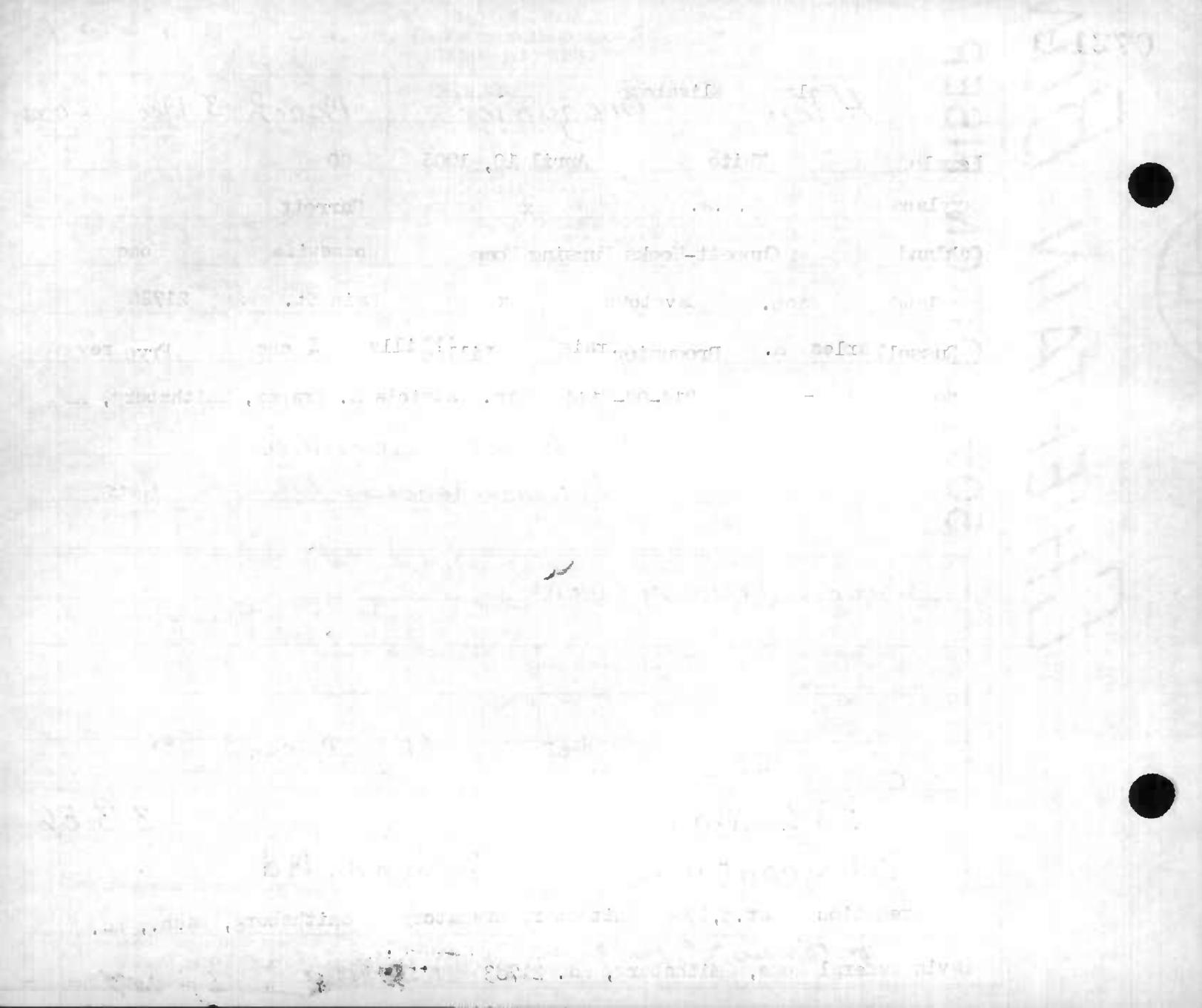
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 0 8 5 3 1				
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Heleen</i>	MIDDLE <i>Elizabeth</i>	LAST <i>Brogunier</i>	2a DATE OF DEATH MONTH DAY YEAR				2b HOUR				
3. SEX Female			4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS				7. IF UNDER 1 YEAR MONTHS DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett				10. IF UNDER 24 HRS HOURS MIN.			
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland			13b. COUNTY Wash.	13c. CITY OR TOWN Cavetown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Main St. 21720							
14. FATHER'S NAME Charles M.			MIDDLE 	LAST Craig	15. MOTHER'S MAIDEN NAME Lilly Irene Frey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 214-09-6144		17. INFORMANT Mrs. Patricia A. Draper, Smithsburg, MD				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			Cerebral Ischemia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Anteriosclerosis											
(c)			DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) chronic brain syndrome														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 30, 1981 to March 3, 1986 , that (I) (we) last saw the deceased alive on Feb 19, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>B. S. Grant</i>			DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3 3 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. S. Grant MD</i>			22e. ADDRESS Oakland, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Mar. 5, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg, Wash., Md.							
24. FUNERAL DIRECTOR NAME <i>Dennis L. Davis</i>			25a. DATE REC'D. BY REGISTRAR MAR 12 1986		25b. REGISTRAR'S SIGNATURE <i>Dennis L. Davis</i>									
DHMH - 16 60M 7/B4 (VRA 15, 4)														



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 6 0 8 5 3 8				
										REG. NO.				
1 - STATE REGISTRAR			RELEASED NAME Abbie Vansant			FIRST MIDDLE LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
									March 25, 1986				2:15P M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			JUNE 20, 1889			96	MONTHS	YEARS	MONTHS	HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA							Garrett				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Oakland			Garrett Co. Memorial Hospital						Bookkeeper					
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE				
Maryland			Garrett		Oakland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			517 E. Alder Street 21550				
14 FATHER'S NAME			MIDDLE		LAST		15 MOTHER'S MAIDEN NAME							
James			Edward		Chance		Katherine Oakley Vansant							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS					
No			213-24-5611			Thomas D. Browning - Oakland, Maryland			307 N. 4th Street 21550					
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) pneumonia, pulmonary edema, dehydration														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from 3/22/1986 to 3/22/1986 , that (I) (we) last saw the deceased alive on 3/22/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE Margaret A Kaiser										22c DATE SIGNED 3/26/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
KAISER			311 N 4th Suite 3 Oakland, Md											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN			COUNTY		STATE
Burial			3/28/86			Oakland Cemetery			Oakland			Garrett		Md.
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR/THE REGISTRAR'S SIGNATURE								
Durst Funeral Home			- Oakland, Maryland 21550			MAR 31 1986								

11910-00

over 1000' and response times are

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

070011

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 3 9

REG. NO.

1. RELEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Floyd Charles CARSKADON			March 5, 1986	6:43A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS
Male	White	June 9, 1905	80	YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.	
W. Va.	USA			
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman
Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Star Rt. 2 Box 176 21550
14. FATHER'S NAME George	MIDDLE	LAST Carskadon	15. MOTHER'S MAIDEN NAME Laura	Cristman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. No	17. INFORMANT	ADDRESS Mildred Carskadon - same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fewsl Fibre</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hodgkin's Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>mother</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one month</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 17/76</i> , 1985, to <i>3/5</i> , 1986, that (I) (we) last saw the deceased alive on <i>19</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I did not) view the body after death.				
22b. SIGNATURE <i>H. Johnson</i> DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>3/5/86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas G. Johnson, M.D.			22e. ADDRESS Fourth St. Oakland, Maryland 21550	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/7/86	23c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery	23d. LOCATION CITY OR TOWN Terra Alta	COUNTY Preston STATE W. Va.
24. FUNERAL DIRECTOR NAME <i>Brent M. Durst</i>	ADDRESS P.O. Box 243 Oakland, MD	25a. DATE <i>3/10/86</i>	25b. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Brent M. Durst</i>
DURST FUNERAL HOME				

521670

LCI:

100% of cases were
seen by a doctor
within 24 hours.

Only 30% of cases
had been seen by a doctor
within 24 hours.

It is clear - what is important

is to have a good system
of health care delivery.

It is also important to have
a good system of health care delivery.

It is also important to have
a good system of health care delivery.

It is also important to have
a good system of health care delivery.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-01065

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8608540

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
				Anna	Gertrude	CLATTERBUCK	March 6, 1986				600 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
Female		White		Aug. 21, 1901			84								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				MD.				
Maryland		USA					Garrett								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Oakland		Garrett County Memorial Hospital		Teacher/Postmts. Educ./post Office											
13a. STATE Md.						13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route #4, Box 10 21550			
14. FATHER'S NAME FIRST						MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
John						-----		Rafferty		Veronica		Bridget		Condon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO			213-01-5111			Mrs. Elizabeth Calhoun, Caswell Beach, NC			years						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						congestive heart failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.						DUE TO, OR AS A CONSEQUENCE OF (b) sepsis - probably influenza 1 week									
{						DUE TO, OR AS A CONSEQUENCE OF (c) hyperosmolar, nonketotic coma 1 week									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a diabetes, atrial fibrillation															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>) attended the deceased from saw the deceased alive on 3/15/86, and that in (my) (<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>) view the body after death.															
22b. SIGNATURE Margaret Kaiser MD DEGREE															
THE PHYSICIAN'S NAME (TYPE OR PRINT)		KAISER		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-6-86									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial 3/10/86		23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gds.		23d. LOCATION CITY OR TOWN Oakland, Garrett, Maryland		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Bradley A. Stewart ADDRESS Oakland, Maryland 21550						25a. DATE REG'D. BY REGISTRAR MAR 14 1986		25b. REGISTRAR'S SIGNATURE John Henderson							

7-2010-00



DO NOT LOCALIZE NOV 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The [redacted] retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove ~~the~~ Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 4 1

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	RECD. NO.	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Shirley Yvonne CRAVER							March 18, 1986				
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		White		July 22, 1935			50			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Garrett			MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Swanton		Route #1, Box 163				Housewife			Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE					
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route #1, Box 163		21561	
14. FATHER'S NAME FIRST Benjamin						15. MOTHER'S MAIDEN NAME FIRST Delsie					
MIDDLE -----		LAST Kline				MIDDLE -----		LAST McDonald			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		218-80-7341		Mr. Kevin G. Craver, Laurel, Maryland							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Valvular Heart Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1981</u> , to <u>Mar 18, 1986</u> , that (I) (we) last saw the deceased alive on <u>Mar 1, 1986</u> , and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Mancey</i>		DEGREE DO		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas Mancey, DO		22e. ADDRESS Third St., Oakland, Maryland 21550									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/21/86		23c. NAME OF CEMETERY OR CREMATORIAL Maysville Cemetery		23d. LOCATION CITY OR TOWN Maysville, Grant, West Virginia		COUNTY		STATE	
24 FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRY 3/19/86		25b. REGISTRAR'S SIGNATURE <i>Hendell</i>					

2003-00

00-00735

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 4 2
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
David Churchman DeWITT				March 9, 1986				11:25AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		2/28/36			50 YRS			MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY				
Maryland		USA		Garrett			MD.			Co. Roads Dept.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Oakland		Garrett County Memorial Hospital		Employee			Co. Roads Dept.							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Garrett		Oakland		Rt. 1 Box 215		21550						
14. FATHER'S NAME FIRST				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Albert		Cecil		DeWitt, Sr.		Ocie B.		Saucer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no				214-32-3593				Betty Ann DeWitt See #13 above				24 hr		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ <i>Cerebral栓塞</i> 24 hr														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ <i>Cardio pulm. arrest</i> 48 hr														
DUE TO, OR AS A CONSEQUENCE OF (c) _____ <i>Cardio myopathy</i> 3 yrs														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jun 83</i> , to <i>Mar 86</i> , that (I) (we) last saw the deceased alive on <i>Mar 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>H. Johnson</i> DEGREE														
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Thomas Johnson, MD			311 N. Fourth St. Oakland Md. 21550											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
Burial			3/12/86			Garrett Co. Mem. Cdns			Oakland,			Garrett Maryland		
24. FUNERAL DIRECTOR NAME														
Bradley A. Stewart 32 S. 2nd St. Oakland, Md.														
25a. DATE REC'D. BY REGISTRAR MAR 17 1986														
25b. REGISTRAR'S SIGNATURE <i>B. Johnson</i>														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial transit permit. Then please return copy to us. If you do not have copy paper, please attach a separate sheet of paper. With the State Dept. of Health and Mental Hygiene prior to burial, cremation or entombment.

IMPORTANT: If Item 21 is marked on item 18 showing injury or other traumatic event, the medical examiner must be notified of same.

BP _____

20710-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial-transit permit. Then please remove this slip and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, if item 21 is marked "B" (showing injury, or other traumatic event, the medical examiner must be notified).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608543			
										REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Maude Agnes FAUBER						March 23, 1986			2:40 p.m.	
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 18 YEARS	
Female			White			June 19, 1899			86			MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
West Virginia			USA						Garrett			MD	
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Oakland			Garrett County Memorial Hospital			Housewife			Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e STREET ADDRESS / ZIP CODE			
13a STATE Maryland			13b COUNTY Garrett			13c. CITY OR TOWN Oakland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Dennert Rd. Manor N.H. 21550	
14 FATHER'S NAME FIRST Albert			MIDDLE Melvin			15 MOTHER'S MAIDEN NAME Sarah			MIDDLE -----			LAST Houdershelt	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-32-7237			17 INFORMANT Edith Browning			ADDRESS Oakland, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>myocardial failure</i>													
DUE TO, OR AS A CONSEQUENCE OF { (b) <i>atherosclerotic heart disease</i>										10 years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Pneumonia</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <i>about December 35</i> to <i>March 23, 1986</i> , that (I) <input type="checkbox"/> lost sow the deceased alive on <i>March 23, 1986</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.													
22b SIGNATURE <i>W. Naumann</i>			22c. DEGREE <i>MD</i>			ATTENDING <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>3-26-86</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Naumann, MD			22f. ADDRESS Accident Professional Bldg. Accident, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/27/86			23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gdns.			23d. LOCATION CITY OR TOWN Oakland			COUNTY STATE Garrett Maryland	
24 FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS 32 S 2nd St. Oakland, Md.			25a. DATE REC'D. BY REGISTRAR <i>ARRO 2 1986</i>			25b. REGISTRAR'S SIGNATURE <i>J. Parker Stewart for Bradley A. Stewart</i>				
BP _____										DHMH - 16 60M 7/84 (VRA 15, 4)			

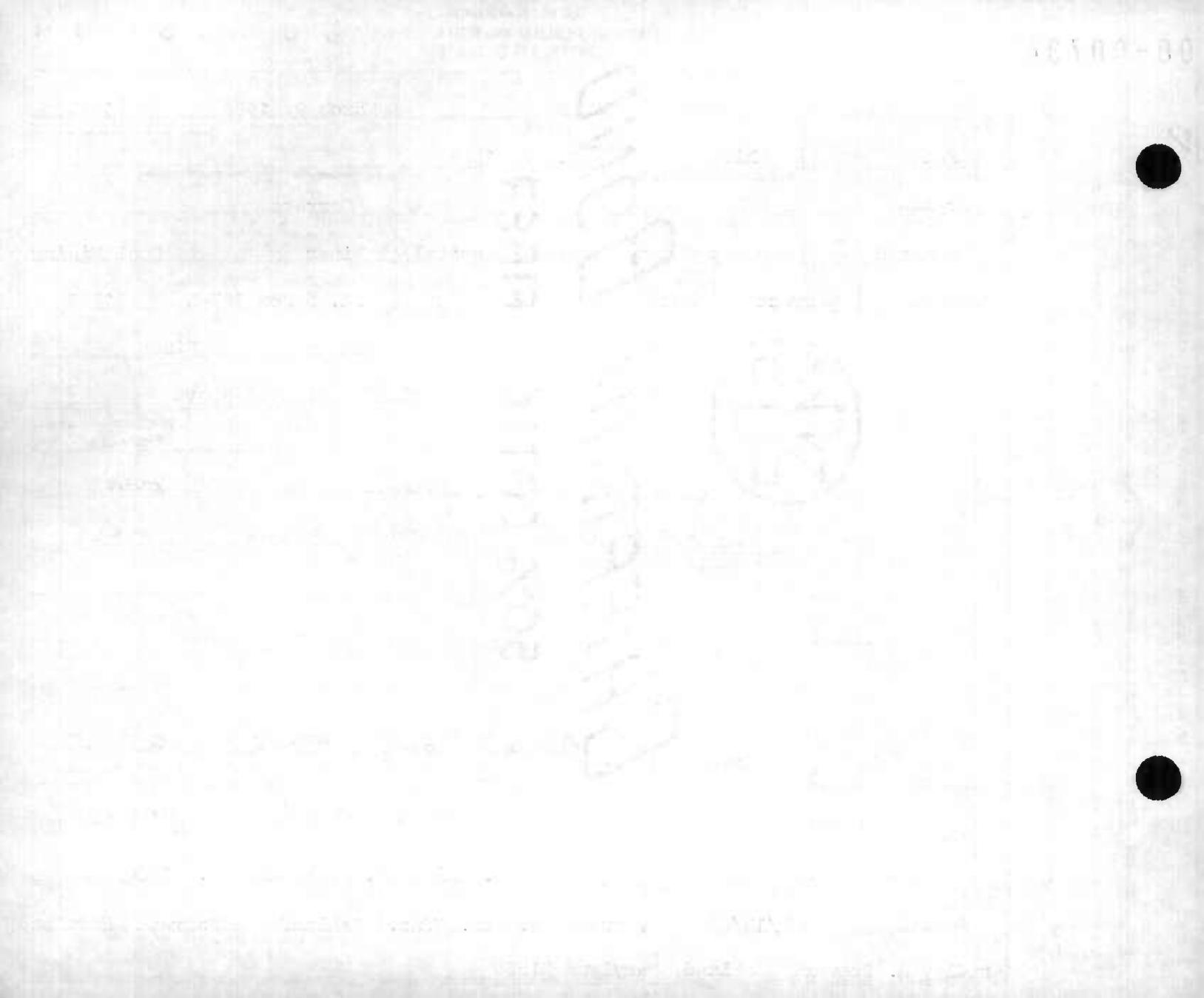
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be left with the funeral director. If item 21 is marked on Item 18 show any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 0 0 8 5 4 4			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Delbert Ross FRIEND						March 9, 1986				12:26pm			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Male		White		Oct. 3, 1922		63 YRS.				MONTHS DAYS			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		USA				Garrett MD.				Coal Mining			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. STREET ADDRESS / ZIP CODE					
Oakland		Garrett County Memorial Hospital		Miner				Rt. 5 Box 307-L 21550					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Garrett		Oakland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 5 Box 307-L 21550					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST				LAST			
Brunner		Franklin		Friend		Edith Esther				Sines			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS					
no		217-14-4345		Laura A. Friend				See #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardium Infarction</u> .										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours -</u>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Disease</u> .										<u>years.</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular Disease</u> .										<u>years.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>Feb 26, 1986</u> , to <u>March 9, 1986</u> , that (2) (we) last saw the deceased alive on <u>March 7, 1986</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Mance</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <u>3/13/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Mance		22e. ADDRESS 3 S. Third St. Oakland, Md. 21550											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/12/86		23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gdns.		23d. LOCATION CITY OR TOWN Oakland,		23e. COUNTY Garrett		STATE Maryland			
24. FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Reese</u>							

10300-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use on the burial transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

DEPARTMENT OF HL. MENTAL HYGIENE
CERTIFICATE OF DEATH8608545
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Mary Elizabeth Harvey				March 25 1986			7:40 a	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr 11 1905	6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co.					
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Mem. Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.	13b. COUNTY Garrett	13c. CITY OR TOWN Kitzmiller	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Main St. 21538				
14. FATHER'S NAME First: Theodore	Middle: Spiker	Last:	15. MOTHER'S MAIDEN NAME First: Annie	Middle:	Last: Duckworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 213 01 6610	17. INFORMANT Mildred Droppleman	ADDRESS Kitzmiller, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute anterior MI</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (c) <u>atherosclerosis</u>				11 days years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>hypertension, influenza</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/25/86</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Margaret Kaiser MD</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-25-86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAI SER	22e. ADDRESS 311 N 4th Suite 3 Oakland, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-27-86	23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem.	23d. LOCATION CITY OR TOWN Oakland	23e. COUNTY Garrett	23f. STATE Md			
24. FUNERAL DIRECTOR NAME David A. Burdock	ADDRESS Kitzmiller, Md. 21538	25a. DATE REC'D. BY REGISTRAR APR 02 1986	25b. REGISTRAR'S SIGNATURE <u>Jeanne Davidson Pendleton</u>					

1st NORMAL MENSTRUATION
Year

1984

MONTH OF PREGNANCY
NATAL CARE BEGAN IN

1st Trimester
1988

072123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-455-6555.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86108546			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Donald				Jackson	Hinebaugh	3-2-86				4:40 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male		White		7/6/1898		87 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Garrett MD.					
Maryland		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Oakland		Garrett County Memorial Hospital		Machinist		Factory worker							
13a. STATE Maryland										13b. COUNTY Garrett	13c. CITY OR TOWN Friendsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 1, Box 197 21531
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST		Ann Lee		ADDRESS					
Thomas		B.		Mary Hinebaugh		Route 1, Box 199A Friendsville, MD 21531							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		210-09-8366 A		Mr. Allen M. Hinebaugh									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiration arrest													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) atherosclerotic vascular disease										years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1977, 19, to 3-2, 1986, that (I) (we) last saw the deceased alive on 2-27-86 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. George Stoltzfus, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-3-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Box 867, Friendsville, MD 21531											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 5, 86		23c. NAME OF CEMETERY OR CREMATORIAL Sand Spring Cemetery		23d. LOCATION Friendsville, Garrett, MD		CITY OR TOWN		COUNTY STATE			
24. FUNERAL DIRECTOR NAME d. Lynn Newman		ADDRESS Grantsville, MD		25a. DATE REC'D. BY REGISTRAR MAR 07 1986		25b. REGISTRAR'S SIGNATURE Luisa Pendee							
DHMH - 16 60M 7/84 (VRA 15, 4)													

151570



00-00903

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8608547

REG. NO.

1 -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Fred C. Iser						March	13,	1986		1:25PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Feb. 3, 1901		85		MONTHS DAYS		HOURS MIN.	
7d BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.						Garrett			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY					
Oakland		Garrett Co. Memorial Hospital		Trackman		Western Md RR.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md.	Garrett	Swanton		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rt 2 Box 216		21561			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS					
John		T.	Iser	Rebecca		Iser					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		705 10 7551		Peggy Murphy Rt 2 Swanton, Md.		3 weeks					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____						Influenza					
DUE TO, OR AS A CONSEQUENCE OF (b) _____						4 weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Obstructive Pulmonary Disease, Organic Brain Syndrome											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
—		—		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from about October 19 86 to March 13 19 86, that (I) was last seen the deceased alive on March 13 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
Walter Naumann		M.D.				3-14-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Accident MD 21520							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		16 March 86		Waxler Cemetery		Rawlings		Allegany		Md.	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Allen Rotruck Keyser, W.VA.				MAR 19 1986		John D. Johnson					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be informed at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and within 24 hours after death. Form 4 may be

submitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it shall be filed with the funeral director. Form 3 may be
submitted by the funeral director. Then please remove carbon paper. Then file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 5 4 8	
										REG. NO.	
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR			21. HOUR
	J Kailer Kidd							March 28, 1986			
2. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		White		8 MON 22 1900 YEAR			85		MONTHS DAYS		HOURS MIN.
7. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Maryland		USA					Garrett County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Oakland		Garrett Memorial Hospital		Attorney			Insurance				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland		Garrett		Oakland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7Th and Alder St.s 21550		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	
		Wm.	C.	Kidd	Loretto					Meeker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		212-07-1900		Mr. Edward Kidd			Barton, Md. 21521				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe debilitation</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b. SIGNATURE <i>D. Daniel Miller</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME <i>D. Daniel Miller</i>		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/86		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery			23d. LOCATION CITY OR TOWN Barton			STATE Allegany Maryland	
24. FUNERAL DIRECTOR NAME Boals Funeral Service		ADDRESS Westernport, Md. 21562		25a. DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE <i>John Boal</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08349

1- STATE REGISTRAR

1 DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Edward Alan LEWIS20. DATE KNOWN MONTH DAY YEAR 08 25 1986
OF ESTI-
DEATH MATED 2b HOUR
2d HOUR

3 SEX

Male

4. RACE

White

5. DATE OF BIRTH
MONTH DAY YEAR

Oct. 22, 1963

6 AGE (IN YEARS
LAST BIRTHDAY)

22 YRS.

7 IF UNDER 1 YR.

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN

2c DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

3 25 1986

2b HOUR
2d HOUR

224P

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED NEVER MARRIED WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Garrett

MD.

10 CITY OR TOWN OF DEATH

Oakland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

(DOA) Garrett Co. Mem. Hosp.

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Laborer

12b KIND OF BUSINESS
OR INDUSTRY

Construction

13a STATE

Maryland

13b. COUNTY

Garrett

13c. CITY OR TOWN

Oakland

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS

Rt. 5 Box 225

21550

14. FATHER'S NAME

Lensey

MIDDLE

Arthur

LAST

Lewis

15. MOTHER'S MAIDEN NAME

Rosetta

MIDDLE

Darlene

LAST

Spiker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

214-86-7272

17. INFORMANT

ADDRESS

Cheryl L. Lewis See #13 above

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Sudden

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Cardiac arrhythmia

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

Valve replacement

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Prior heart valve replacement x 2

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATEAT WORK

22a. I certify that I took charge of the remains described above, held an

Autopsy Inspection Inquiry and in my opinion

death resulted from:

Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURETITLE (SPECIFY)
M.D. DEPUTY MEDICAL EXAMINER

DATE SIGNED 3-25-1986

EXAMINER'S NAME
(TYPE OR PRINT)

James H. Feaster, Jr., M. D. ADDRESS 107 S. 2nd. St., Oakland, Md.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

3/28/86

23c. NAME OF CEMETERY OR CREMATORIUM

Taylor Sines Cemetery

23d. LOCATION
CITY OR TOWN

Oakland

COUNTY

Garrett

STATE

Maryland

24. FUNERAL DIRECTOR
NAME

Bradley A. Stewart

ADDRESS

32 S 2nd St. Oakland, Md.

25a. APPROVED BY REGISTRAR

APR 26 1986

25b. REGISTRAR'S SIGNATURE

John Deacon

87890-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Form 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use in the burial service permit. Then please remove carbons of pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 has any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 0 0 8 5 5 0
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Ella</i>	MIDDLE <i>Mildred</i>	LAST <i>Losh</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>3-25-86</i>
2. SEX <i>Female</i>		3. RACE <i>Caucasian</i>		4. DATE OF BIRTH MONTH DAY YEAR <i>1-18-1912</i>	5. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>74 YRS</i>
6. BIRTHPLACE STATE OR FOREIGN <i>WV</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Garrett</i>
10. CITY OR TOWN OF DEATH <i>Oakland</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Garrett Co. Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housekeeper</i>	
12b. STATE <i>WV</i>		13b. COUNTY <i>Preston</i>		14. CITY OR TOWN <i>Terra Alta</i>	
15. FATHER'S NAME <i>Robert</i>		MIDDLE <i>Grimm</i>	LAST <i></i>	15. MOTHER'S MAIDEN NAME FIRST <i>Berthe</i> MIDDLE <i>Pearl</i> LAST <i>Knotts</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>233-42-8219</i>		17. INFORMANT ADDRESS <i>Sandra Kelly, Rt 7, Terra Alta, WV 26764</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Mycocystin Fracture</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Anemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last days months					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Liver Disease</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Cirrhosis. Esophageal Varices</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital) attended the deceased from <i>Oct</i> , 19 <i>81</i> , to <i>March 25 1986</i> , that (I) (we) last saw the deceased alive on <i>March 25 1986</i> , and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Thomas J. Mauro Jr.</i>		DEGREE <i>Jr</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>3/30/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>35-370 Oaklawn Rd 21588</i>			
23a. BURIAL, CREMATION, REMOVAL (IF OTHER) <i>Burial</i>		23b. DATE <i>3-29-86</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Terra Alta Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR <i>John K. Whitehair</i>		ADDRESS <i>P.O. Box 46</i>	25a. DATE REC'D. BY REGISTRAR <i>7</i>		25b. REGISTRAR'S SIGNATURE <i>John K. Whitehair</i>

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 5

REG. NO.

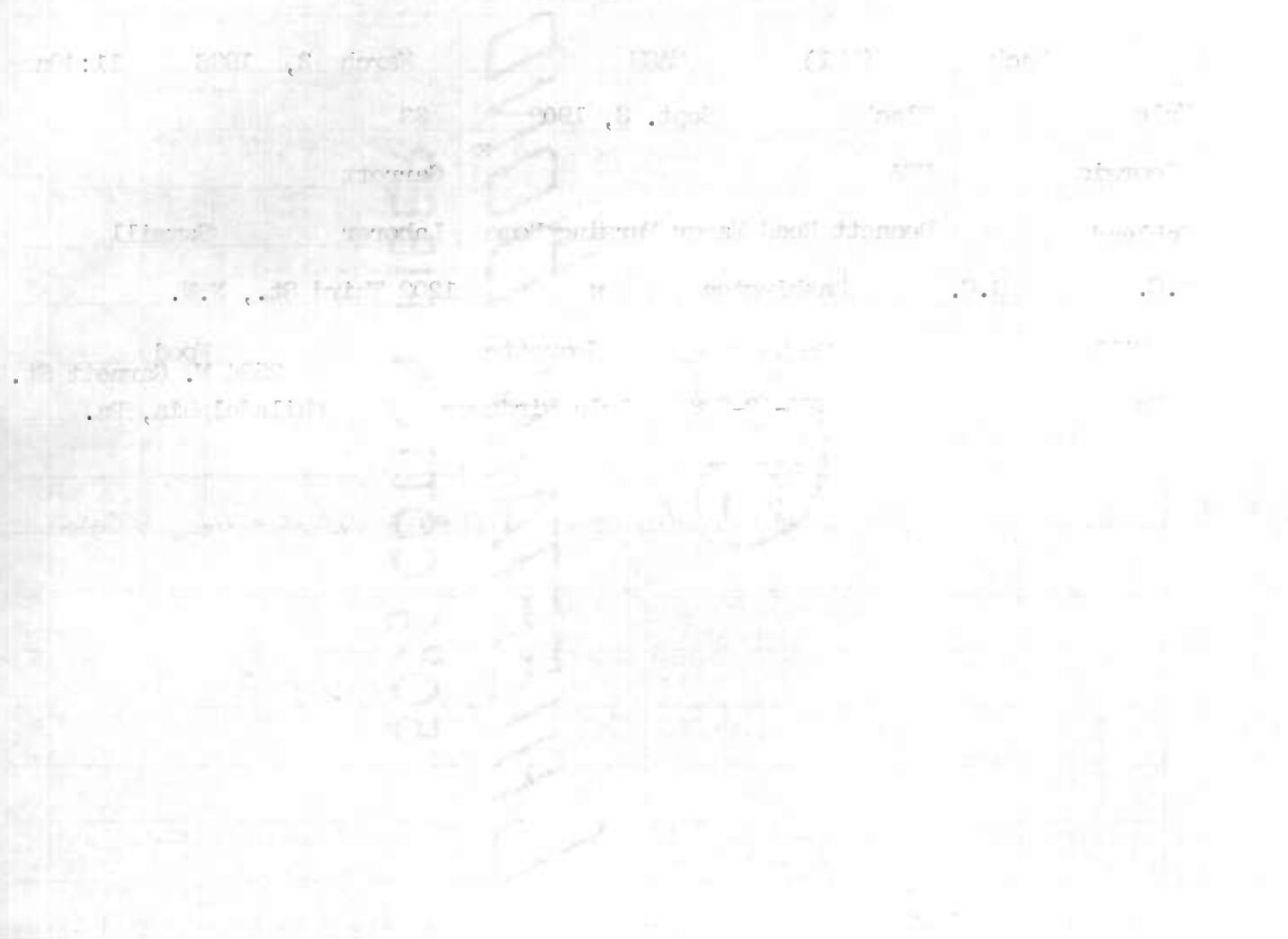
1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Mack (NMI) NASH			March 3, 1986	11:40 a.m.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		
Male	Black	Sept. 8, 1902		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Georgia	USA	83 yrs		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Oakland	Dennett Road Manor Nursing Home			Laborer
13a. STATE D.C.	13b. COUNTY D.C.	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1202 Third St., N.W. 99999
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE LAST
Will		Nash	Jeanette	Wood
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS 2524 N. Garnett St.	
No	577-40-6985	Lula Birdsong	Philadelphia, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Disease generalized</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>19-78</u> , 19_____, to <u>3-3</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>George B. Stoltzfus</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS Friendsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/6/86	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION CITY OR TOWN Oakland	COUNTY STATE Garrett Maryland
24. FUNERAL DIRECTOR NAME Durst Funeral Home	ADDRESS Oakland, Maryland 21550	25a. DATE REC'D. BY REGISTRAR MAR 10 1986	25b. REGISTRAR'S SIGNATURE Jane Davidson-Pendleton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be submitted by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPRT NT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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January 1970
benton hillman - rufus western traffic - mitchell - hubert
and lewellyn bay

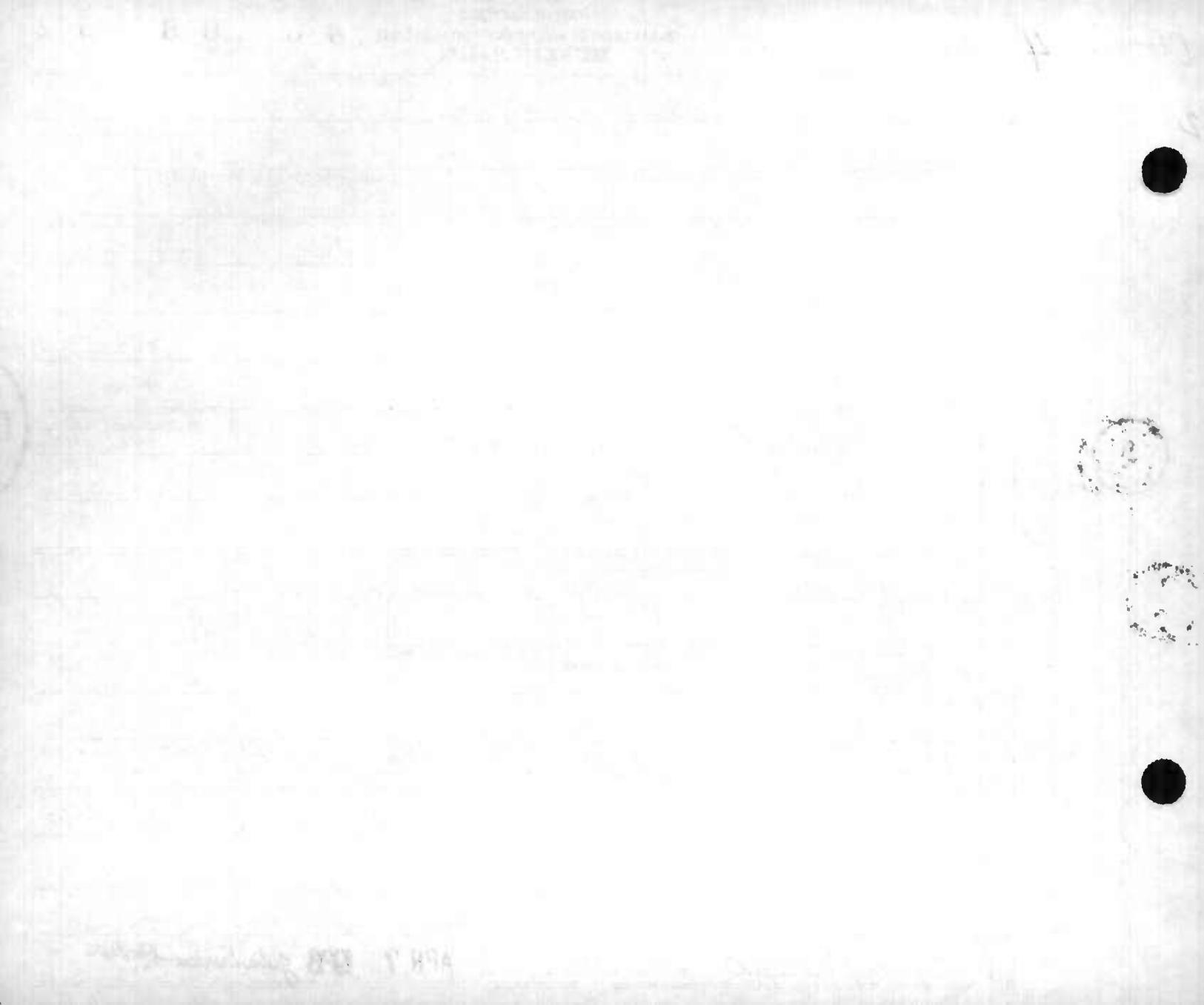
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be forwarded to the funeral director. Then please remove certificate from Pages 1 and 2. It should be filed with the State Office of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked and item 22 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 8 5 5 2			
										REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	3/31/1986			4:52 p.m.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		9/1/1907			78 yrs						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA					Garrett						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		Garrett County Memorial Hospital							Laborer			various jobs	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland	Garrett	Accident						Route 2, Box 89			21520		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST	Kolbfleisch			
John				Patton	Minnie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
--			214-12-3250			Mrs. R. Nora F. Patton			Route 2, Box 89			Accident, MD 21520	
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
cardiac arrest										40 min			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____										years			
atherosclerosis													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a recent exacerbation of angina in the last week													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/31/1986, to 3/31/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Margaret A. Kaiser MD										22c. DATE SIGNED 3/31/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAISER			22e. ADDRESS Garrett Co Hospital										
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 4/3/1986			23c. NAME OF CEMETERY OR CREMATORIUM Grantsville Cemetery			23d. LOCATION CITY OR TOWN Grantsville, Garrett, md				
24. FUNERAL DIRECTOR N. Lynn Neuman			25a. DATE REC'D. BY REGISTRAR APR 7							25b. REGISTRAR'S SIGNATURE John Gardner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use by the funeral parlor. Then please remove carbon paper. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" (B) above, any injury, ailment, or other traumatic event, not medical in nature,

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 6 0 8 5 5 3

1 - STATE REGISTRAR 4/10/86 rja

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Minnie Eleanor RODEHEAVER						March 28, 1986				8:40 p m		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		White		Feb. 19, 1897		89						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.A.				Garrett						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Oakland		Garrett County Memorial Hospital				Practical Nurse		Nurse				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland			138 N. Centre St. 21502							
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE	LAST					
Ami			Teets	Marion			Glotfelty					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No				220-16-7192A		F. June Cook		151 Ormand Street Frostburg, MD 21532				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Respiratory Failure								hours				
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia												
DUE TO, OR AS A CONSEQUENCE OF (c) _____								days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that 0 (this hospital) attended the deceased from Oct 1981 to March 28, 1986 , that 0 (we) lost sow the deceased alive on March 28, 1986 , and that in 0 (our) opinion death occurred on the date and hour and from the causes stated above. 0 (we) (did) (did not) view the body after death.												
22b. SIGNATURE Thomas Mance			22c. DEGREE D.O.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 3-28-86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Mance, D.O.			23c. ADDRESS Third Street - Oakland, Maryland 21550									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3/31/86		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial		23d. LOCATION CITY OR TOWN Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Jane Davidson-Pendell							
			230 Baltimore Ave. Cumberland, MD 21502		APR 01 1986							

2000 00 00000



2000 00 00000



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 5 4

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Loyal Emerson				Simon			3	4	86	4:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		white		Jan, 18 1922			64			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 21 HRS	
WV		U.S.A.					Garrett			MONTHS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Oakland		Garrett Co. Memorial Hosp.			Retired			United Airlines			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE		13b. COUNTY		14. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
WV		Mineral		Elk Garden		Rt. 4 Bx. 564 Keyser, WV26726		99999			
15. FATHER'S NAME FIRST		MIDDLE		16. MOTHER'S MAIDEN NAME FIRST		17. INFORMANT		ADDRESS			
Arna		Simon		Estella		P.		Bray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
Yes		WW 2		235-30-0712M. Simon			Rt. 4 Bx. 564 Keyser, WV26726				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>inferior myocardial infarction</u> 10 hr DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/31/1986 to 3/4/1986, that (I) (we) last saw the deceased alive on 3/4/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			
Margaret KAISER		311 N 4th Oakland, Md 21550			3/4/86						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN				
cremation		3-7-86		Davis Crematory			Smithburg Washington Md				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
D.A. Burdock Kitzmiller, Md. 21538		MAR 7 1986					Burdock Kitzmiller				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed with item 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked off Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

00-00907

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 6 0 8 5 5 5
REG. NO.

1 - STATE REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Iva	Mae	Slaubaugh	March 9, 1986			10:05 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Dec. 10, 1892		93		YRS		MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
WV.		USA						Garrett			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Oakland		Garrett County Memorial		homemaker		Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE Wv.		13b. COUNTY Preston		13c. CITY OR TOWN Horseshoe Run		13e. STREET ADDRESS / ZIP CODE Rural 99999					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Albert		Wellington		Slaubaugh		Ameila		Ann		Harsh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		232-72-0082		Beulah Hardesty		Aurora, WV.					
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-5 days					
DUE TO, OR AS A CONSEQUENCE OF (i) _____ Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last						years					
DUE TO, OR AS A CONSEQUENCE OF (ii) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19a.						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (ii) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did (did not) _____ the body after death.											
22b. SIGNATURE <i>R.E. Hinkle MD</i>		22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 10 March 86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		3/12/1986		Texas cemetery		Horseshoe Run, Preston		WV.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lester R. Hinkle		Davis, WV.		MAR 20 1986		<i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this document be signed by the physician or attending physician, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician or attending physician, it should be detached for use as the burial/transit permit. Then please return carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

999999

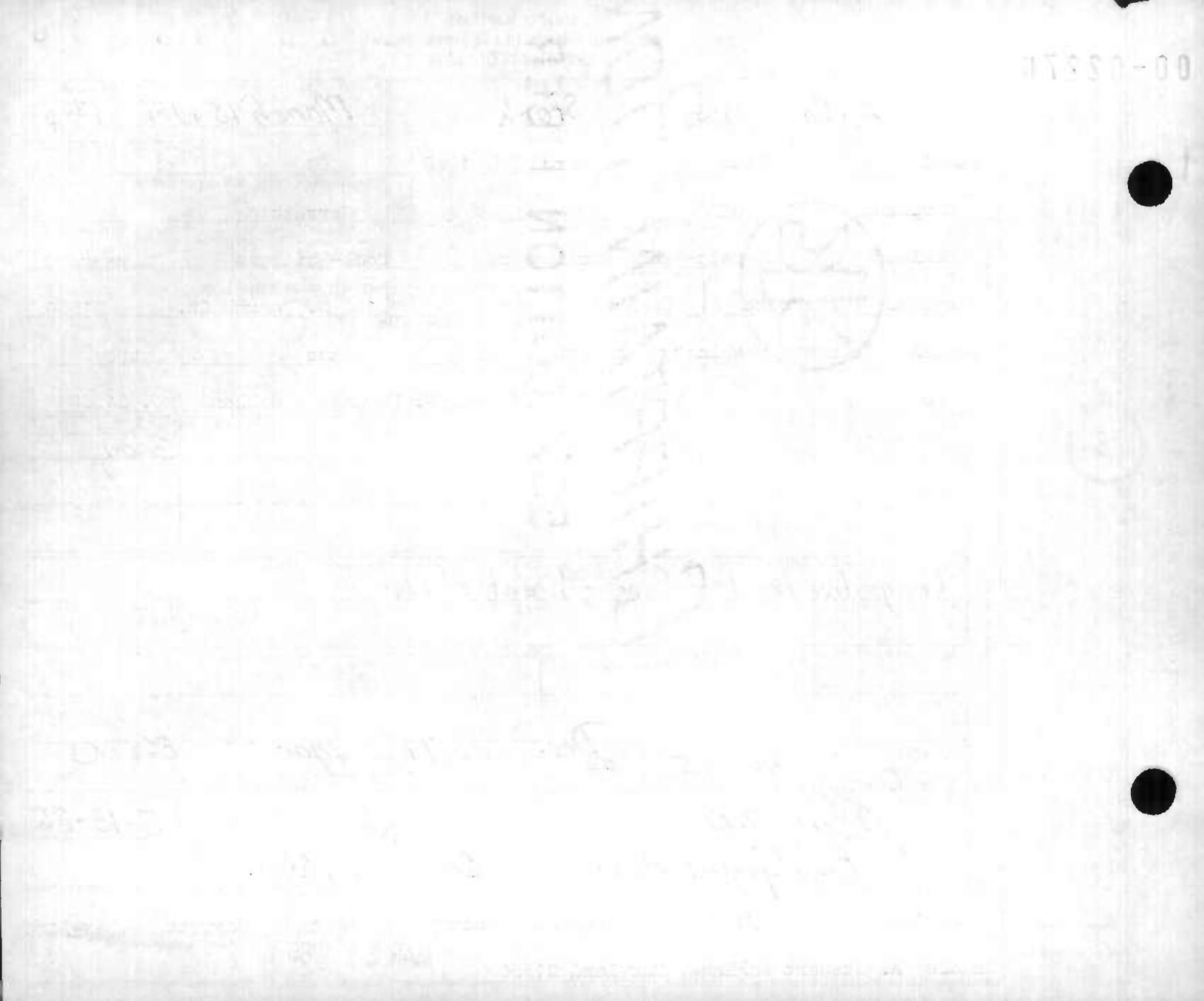
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial/transit permit. Then please remove certificate. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 0 8 5 5 6					
												REG. NO.					
1. FOR STATE REGISTRAR			FIRST Lula			MIDDLE Alice			LAST Stark			2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME												March 15 1986				130 p.m.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Female			White			Month March Day 25 Year 1896			89 YRS.			MONTHS			DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Garrett MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Oakland			Cuppett-Weeks Nursing Home			Cook-Waitress			Restaurant								
USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION												13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
13a. STATE Maryland			13b. COUNTY Garrett			13c. CITY OR TOWN Oakland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			127 N. Fourth St. 21550					
14. FATHER'S NAME FIRST Lemuel			MIDDLE George			LAST Washington Stewart			15. MOTHER'S MAIDEN NAME FIRST Rose			MIDDLE Etta			LAST Harvey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			214-12-3225			Mildred G. Maroney			Oakland, Md. 21550			3 days					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <i>Pneumonia</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive Heart Failure - heart block.</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1985</i> to <i>Mar 1986</i> , that (I) we lost saw the deceased alive on <i>Mar 15 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We/They did not view the body after death.)																	
22b. SIGNATURE <i>B.L. Grant M.D.</i>												DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED								
B.L. Grant M.D.			Oakland, Md.									3-15-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____								
Burial			3/18/86			Oakland Cemetery			Oakland Garrett Maryland								
24. FUNERAL DIRECTOR NAME <i>Bradley A. Stewart</i> ADDRESS <i>Oakland, Maryland 21550</i>												25a. DATE REC'D. BY REGISTRAR					
												25b. REGISTRAR'S SIGNATURE					
												MAR 31 1986					

77031-00



00-00148

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 5 5 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Pagers 1 and 2 should be filled in within 24 hours after death.

IMPORTANT: If item 21 is marked on page 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) Jeremiah Glendon TASKER				2a. DATE OF DEATH March 4, 1986	MONTH YEAR	DAY	2b. HOUR 1:20 a.m.
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 12, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 63 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming
13a. STATE Maryland 13b. COUNTY Garrett 13c. CITY OR TOWN Deer Park 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE P.O. Box 3125 21550							
14. FATHER'S NAME FIRST Alphonso		MIDDLE Tescumseh	LAST Tasker	15. MOTHER'S MAIDEN NAME FIRST Addie		MIDDLE Pearl	LAST Dawson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 220-16-6261		17. INFORMANT Vivian Hardesty		ADDRESS Deer Park, Md. 21550	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>acute respiratory arrest + Anoxic brain injury</u> 2/24/86 DUE TO, OR AS A CONSEQUENCE OF (c) <u>pneumonia</u> 2/28/86							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/04/86							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>severe chronic obstructive pulmonary disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> , 19 <u>86</u> , to <u>3/3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Donald R. Richter MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/5/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. Richter, MD.		22e. ADDRESS 311 N. Fourth Street, Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/86	23c. NAME OF CEMETERY OR CREMATORIAL Tasker Cemetery		23d. LOCATION CITY OR TOWN Deer Park Garrett Maryland	COUNTY	STATE
24. FUNERAL DIRECTOR NAME Bradley A. Stewart 32 S 2nd St. Oakland, Md.							
25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE MAR 10 1986 John Davidson-Henderson							

10100-00



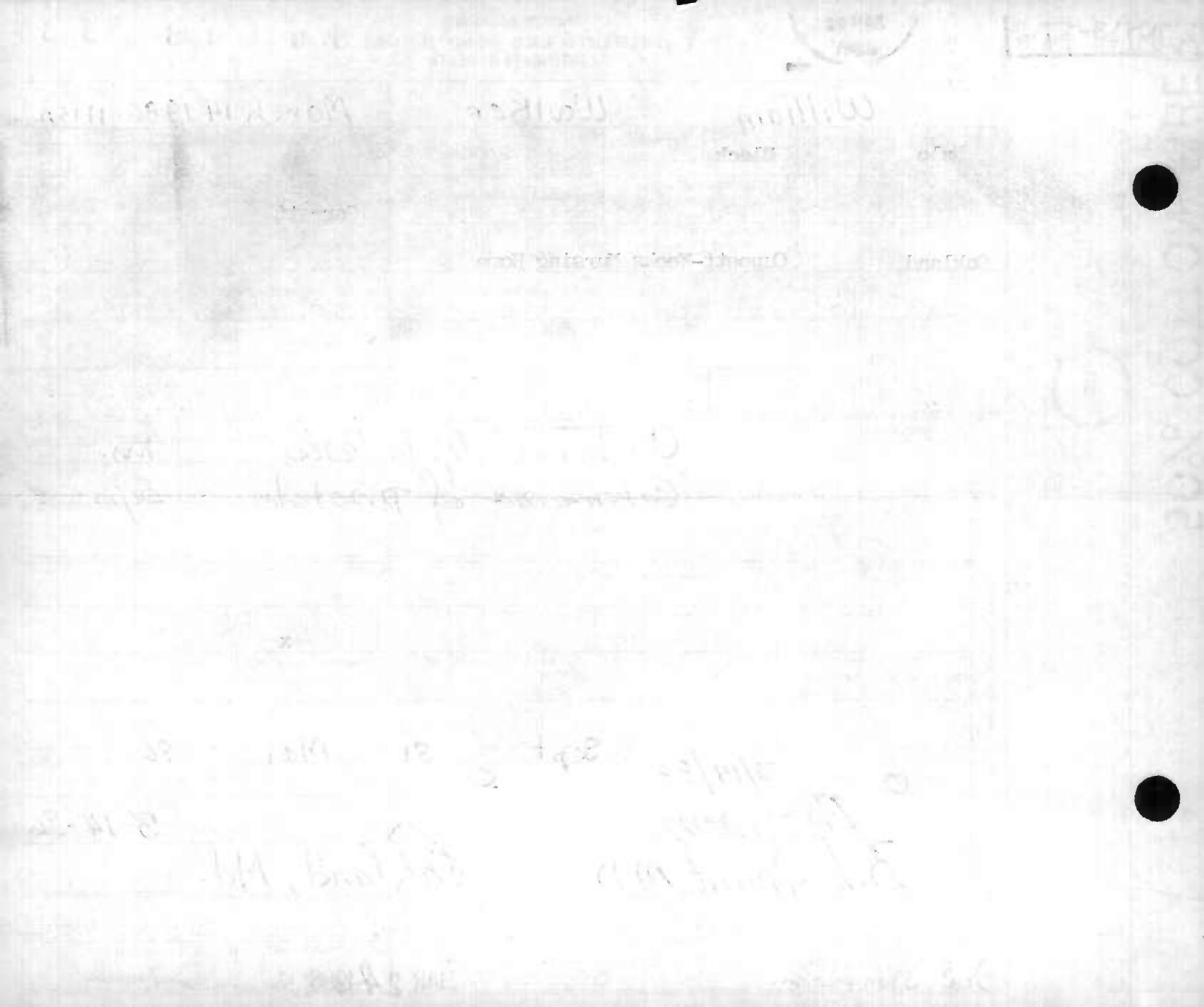
00-0149

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>William</i>	MIDDLE <i>Walker</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR	MONTH	DAY	YEAR	2b. HOUR 1115 AM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett				
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Clerk		12b. KIND OF BUSINESS OR INDUSTRY Department store			
13. STATE Virginia		13b. CITY OR TOWN Culpeper		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1106 S. Main St. 22701			
14. FATHER'S NAME FIRST Reuben		MIDDLE <i>Walker</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST Jennie		MIDDLE	LAST Jackson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mildred W. Winters (sister)		ADDRESS 4960 Eastern Ave. N.E. Washington, D.C. 20017			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Metastasis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Prostate</i>		5 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sep</i> , 19 <i>81</i> , to <i>Mar</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>3/14/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B.G. Grant</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>3-14-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B.L. Grant M.D.</i>		22e. ADDRESS <i>Oakland, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/86		23c. NAME OF CEMETERY OR CREMATORIAL Culpeper National Cem.		23d. LOCATION CITY OR TOWN Culpeper		COUNTY Culpeper	STATE Virginia
24. FUNERAL DIRECTOR NAME <i>J.C. Thompson's Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR MAR 26 1986		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson Pendleton</i>					
DMMH - 16 60M 7/84 VRA 15. 4									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial/transit permit. Then please attach this certificate to the death report form and mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "No" shows no injury, or other traumatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 6 0 8 5 5 9		
					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Leland Clyde Welch			3	21	86		2:05 P.M.
3. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White	7 14 1914	71		MONTHS	DAYS
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
WV		U.S.A.		Garrett			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (IF WORKER, STATE TYPE OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Oakland		Garrett Co. Memorial Hosp.			Retired		Coal Miner
13a. STATE 13b. COUNTY Md. Garrett					13c. CITY OR TOWN Kitzmiller		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE Bx. 643 Kitzmiller, Md21538		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Edger			Corra Lee				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS				
No		212-12-8520	Roger Welch Bx. 643 Kitzmiller, Md21538				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>Underdeveloped Aorta</u> Metastatic (c) <u>Murky</u>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>COPD</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 80</u> to <u>3/21 86</u> , that (I) (we) last saw the deceased alive on <u>3/21 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Holmes</u> DEGREE							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. DATE SIGNED <u>3/24/86</u>		
+ Johnson		311 North St. Oakl (rd) w					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial		3/23/86	Mt. Zion		Mt. Zion	Garrett	Md
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
D.A. Burdock Bx. 523 Kitzmiller, Md.				MAR 31 1986		John Davidson - Pendell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned by the hospital or attending physician, it should be detached from the burial-transit permit. Then please remove carbon copies. Please send with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 0 0 8 5 6 0							
					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR 2b HOUR							
Elva		Arlene	WILT		March 31, 1986 8:08p M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR								
Female		White		Jan. 25, 1925								
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>								
Maryland		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								
Oakland		Garrett County Memorial Hospital		Housewife								
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 115 W. Main St. 21532		12b. KIND OF BUSINESS OR INDUSTRY Home		
14. FATHER'S NAME John		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Bessie		MIDDLE	LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
no		212-24-1101		Shirley Lucas, Mt. Lake park, Md. 21550								
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anute/Chronic Congestive Heart Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Anute/Chronic Renal Failure</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
_____		_____		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from <u>January 31, 1986</u> to <u>3/31/86</u> , that (I) (we) last saw the deceased alive on <u>3/31, 1986</u> , and that (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Karl F. Schwalm</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>3/31/86</u>						
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Karl F. Schwalm</u>		22g. ADDRESS <u>Oakland, MD 21550</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/3/86		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cem.		23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____		25a. DATE REC'D. BY REGISTRAR APR 16 1986				25b. REGISTRAR'S SIGNATURE <u>John J. Schindler</u>
24. FUNERAL DIRECTOR NAME _____ ADDRESS _____ Bradley A. Stewart 32 S 2nd St. Oakland, Md.												

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